

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-002409

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 387

Primary Registration District No. 3099

Registrar's No. 809

FILED FEB 13 1963

1. PLACE OF DEATH a. COUNTY <u>LINN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>CHARITON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>BROOKFIELD</u>		Length of stay in lb <u>1 1/2 hr.</u>	c. CITY OR TOWN <u>SUMNER</u>
c. FULL NAME OF (If NOT in Hospital, give location) <u>Doctors Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>SUMNER MO</u>
3. NAME OF DECEASED (Type or print) First <u>Nova</u> Middle <u>EDWARD</u> Last <u>WHEELBARGER</u>		4. DATE OF DEATH Month <u>2</u> Day <u>6</u> Year <u>1963</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1-15-1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <u>77</u>
11a. FATHER'S NAME <u>Unknown</u>		11b. MOTHER'S MAIDEN NAME <u>Unknown</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>no</u>		13. SOCIAL SECURITY NO. <u>Walter WHEELBARGER-SUMNER MO</u>	
14. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY) IMMEDIATE CAUSE (a) <u>Congestive Circulatory Failure</u>		15. IF UNDER 1 YEAR Months <u>21</u> Days <u>21</u> Hours <u>21</u> Min. <u>21</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Decompensated Hypertensive Heart Disease</u>		16. CITIZEN OF WHAT COUNTRY <u>USA</u>	
DUE TO (c) <u>Arteriosclerosis</u>		17. NAME OF HUSBAND OR WIFE	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Anemia</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>12</u> a.m. <u>15</u> p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>SUMNER MO</u>
21. I attended the deceased from <u>8-14-58</u> to <u>2-6-63</u> and last saw him alive on <u>2-6-63</u>		22. DATE SIGNED <u>2-7-63</u>	
Death occurred at <u>12:15 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <u>Norman E. Hansen D.O.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>2/8/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>hakeside</u>
24. FUNERAL DIRECTOR <u>S. L. Lippard</u>		25. DATE RECD. BY LOCAL REG. <u>2-7-63</u>	26. REGISTRAR'S SIGNATURE <u>Anna Watson</u>

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK

OR

TYPEWRITER RIBBON

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Rev. 4/59

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

L. R. Lipard

Licensed Embalmer No.

3970

P. O. Address

Mendon MO

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.